State Health Benefit Plan

APPLICATION FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL DUE TO INVOLUNTARY TERMINATION OF EMPLOYMENT 9/1/08 – 5/31/10

[If you lost SHBP coverage while still employed because your hours were reduced, and then you later experienced a termination of employment, please contact SHBP for the Special Reduction in Hours AEI Form]

This official statement by you, your dependents, and your former employer is required to prove that you and any dependents eligible for COBRA are allowed to receive COBRA coverage by paying only 35% of the COBRA premium. **This is NOT an SHBP COBRA Enrollment Form.**

1. **Complete the parts of this form marked "Employee."**
2. **Have each Dependent complete the part of this form marked "Dependents."**
3. **Have your Human Resources Manager complete the part of the form marked "HR Manager."**
4. **Return the completed form with your SHBP COBRA Enrollment Form (if you are not already on COBRA) OR send this form separately by addressing it: State Health Benefit Plan, P.O. Box 1990, Atlanta, GA 30301-1990, ATTN: COBRA Premium Reduction**
5. **Keep a copy of the signed form.**

Note: You may also want to read the important information about your rights included in the "Summary of the COBRA Premium Reduction Provisions Under ARRA, As Amended."

EMPLOYEE:PERSONAL INFORMATION

Employee First Name: _____ Last Name: _____

Street: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Social Security No. _____ Telephone #: _____

(List all dependents on the reverse side of this form.)

EMPLOYEE: (To qualify, you must be able to check 'True' for all statements.)*

1. The loss of employment was involuntary, because it was the direct result of an action taken by my employer while I was ready, able and willing to keep working. **.	☐ True ☐ False
2. The loss of employment occurred at some point during the period starting on September 1, 2008 and ending on May 31, 2010.	☐ True ☐ False
3. I elected (or am electing) COBRA continuation coverage on the separate SHBP COBRA Enrollment Form.*	☐ True ☐ False
4. I am NOT able to enroll right away in another group medical plan (or I was not able to enroll right away in another group medical plan during the period for which I am claiming a reduced premium).	☐ True ☐ False
5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium).	☐ True ☐ False
Signature	
***If you checked FALSE for statement 1, you may still be eligible. See below for more information.** **Examples of involuntary loss of employment include being fired, being laid off, nonrenewal of contract, reduction in hours to zero, and elimination of your job for the convenience of your employer. The loss of employment can be involuntary even if you resigned or retired, if the reason you resigned or retired was because you were told that otherwise your employment would be terminated for one of the above reasons. In addition, if you resigned or retired because of an important adverse change in your employment caused by your employer, such as a furlough, significant reduction in your hours or pay, or mandatory relocation, your resignation or retirement is considered an involuntary loss of employment.	**Date**

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)

A. _____

Name | Date of Birth | Relationship to Employee | SSN (or other identifier)

1. I elected (or am electing) COBRA continuation coverage on the separate SHBP COBRA Enrollment Form.	☐ True ☐ False
2. I am NOT able to enroll right away in another group medical plan.	☐ True ☐ False
3. I am NOT eligible for Medicare.	☐ True ☐ False

I make an election to exercise my right to the COBRA/ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

B. _____

Name | Date of Birth | Relationship to Employee | SSN (or other identifier)

1. I elected (or am electing) COBRA continuation coverage on the separate SHBP COBRA Enrollment Form..	☐ True ☐ False
2. I am NOT able to enroll right away in another group medical plan.	☐ True ☐ False
3. I am NOT eligible for Medicare.	☐ True ☐ False

I make an election to exercise my right to the COBRA/ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

C. _____

Name | Date of Birth | Relationship to Employee | SSN (or other identifier)

1. I elected (or am electing) COBRA continuation coverage on the separate SHBP COBRA Enrollment Form..	☐ True ☐ False
2. I am NOT able to enroll right away in another group medical plan.	☐ True ☐ False
3. I am NOT eligible for Medicare.	☐ True ☐ False

I make an election to exercise my right to the COBRA/ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

HR Manager at Payroll Location (You must check an answer for each question.)

1.	The employee's employment was involuntarily terminated for one of the following reason: Layoff (with or without recall rights) Reduction in hours to zero Termination for cause (other than for "gross misconduct") Termination for convenience Elimination of the job Non-renewal of contract by the employer	☐ True ☐ False
2.	The **employee resigned or retired after getting a notification of his or her upcoming termination** of employment as described in 1. above.	☐ True ☐ False
3.	The employee resigned or retired after the employer made a significant, adverse change to the employment relationship, such as mandatory relocation, reduction in hours, reduction in pay, furlough.	☐ True ☐ False
4.	I checked "False" to 1., 2., and 3. above, but for the following reason, the termination of employment was "involuntary." (Describe reason) _____ _____ _____ _____	☐ True ☐ False
5.	The termination of employment occurred during the period starting September 1, 2008 and ending May 31, 2010.	☐ True ☐ False
6.	The employee has lost or will be losing SHBP coverage as a result of the termination described above. ***NOTE: If the employee lost SHBP coverage in the past due to a reduction in hours and later experienced a termination of employment, the Special AEI Reduction in Hours Application should be completed instead of this form.***	☐ True ☐ False
	Payroll Location #: ➔ _____ Payroll Location Name ➔ _____ Signature of Payroll Location HR Manager ➔ _____ _____ Date ➔ _____ Type or print name ➔ _____ Telephone number ➔ _____ E-mail address ➔ _____	☐ True ☐ False

FOR SHBP USE ONLY

This application is: ☐ Approved ☐ Denied ☐ Approved for some/denied for others (explain in #3 below)
Specify reason below and then return a copy of this form to the applicant

REASON FOR DENIAL OF COBRA PREMIUM REDUCTION REQUESTED (TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL)

1. Loss of employment was voluntary.	☐ True☐ False
2. The involuntary loss of employment did not occur between September 1, 2008 and May 31, 2010.	☐ True☐ False
3. Other (please explain) _____ _____	